The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 4 November 2014

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
28th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Christine McLaughlin (Scottish Government)
Alex Neil (Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health and Sport Committee

Tuesday 4 November 2014

[The Convener opened the meeting at 09:45]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning, and welcome to the 28th meeting in 2014 of the Health and Sport Committee. I ask everyone to switch off mobile phones, because they can interfere with the sound system. That said, some officials and members are using tablets instead of hard copies of papers.

Our first item is a decision on whether to take items 3 and 4 in private. Item 3 is consideration of the evidence that we have received on the draft budget, to inform the committee's report. Item 4 is the committee's revised approach to the Assisted Suicide (Scotland) Bill. Do members agree to take those items in private?

Members *indicated agreement.*

Draft Budget Scrutiny 2015-16

09:46

The Convener: We move to item 2 and begin our second session in our annual scrutiny of the Scottish Government's draft budget for the coming year, 2015-16. It seems to have been a wee while since we welcomed the Cabinet Secretary for Health and Wellbeing, who joins us this morning along with Christine McLaughlin, who is deputy director of finance, health and wellbeing for the Scottish Government. Welcome to you both. I give the cabinet secretary an opportunity to make an opening statement before we move to questions.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you for inviting me to discuss the draft budget for 2015-16. As always, I welcome the opportunity to give evidence on this most important of subjects, ensuring that there is fair and appropriate funding for the national health service in Scotland—an asset that is precious to us all.

Over the next few years, the demand for health and social care and the circumstances in which it is delivered will become radically different. NHS Scotland must work with its partners across the public and voluntary sectors to ensure that it continues to provide the high-quality health and social care services that the people of Scotland expect and deserve, thereby securing the best possible outcomes for people through the care and support that they receive.

It is in that context that we have developed our vision that, by 2020, everyone will be able to live longer and healthier lives at home or in a homely setting. During 2012, a route map to the 2020 vision for health and social care was developed and has continued to provide a focus on the priorities that will have the greatest impact on achievement of our vision. The route map describes 12 priority areas for action in three domains: first, improving the quality of the care that we provide; secondly, improving the health of the population; and thirdly, securing the value and financial sustainability of the health and care services that we provide. I believe that those three aims must be central, and are central, to our funding commitments, which are contained in the 2015-16 draft budget, and I shall briefly set out how that is the case.

We are focused on ensuring that the care that people receive is person centred, safe and effective. People expect services that work in a co-ordinated way with them, that understand what matters most in their lives and which build support around achieving the outcomes that are important to patients. The integration of care puts in place a

framework to ensure that health and social care services are planned, resourced and delivered together by NHS boards and local authorities in order to improve outcomes for the people who use the services, their carers and their families. That is why we are allocating £100 million to support integrated partnerships and a further £73.5 million—an increase of £53.5 million on the £20 million that was previously announced—to support the development of new models of care in local areas.

In addition, ensuring appropriate care and treatment for people who require specialist and often expensive medicines for rare conditions remains a priority. That is why we are investing £40 million through the new medicines fund. That doubles the commitment that I made last year. Last year's investment supported the costs of 45 different medicines, which benefited more than 200 patients. By doubling the investment, we will see the fund having an even greater impact in 2015-16.

NHS Scotland plays a vital role in improving and maintaining the good health of the people of Scotland as a whole, and in reducing health inequalities. The 2015-16 draft budget includes an additional £4.4 million to support the continued expansion of the family nurse partnership programme, with a focus on supporting parents in deprived communities. There will be an additional £4.6 million to support the extension of the immunisations programme, and £8 million will be used for the getting it right for every child programme to support the provision of person-centred, safe and effective care for women and babies.

Although Scotland's health is improving, it is improving more slowly than comparable European countries. We will therefore continue to pursue a preventive agenda with on-going resources being committed to alcohol intervention, to reducing smoking rates and to improving oral health.

It is also essential that we secure the value and financial sustainability of our health and social care services. The most dramatic reduction in public spending that has ever been imposed on Scotland by the United Kingdom Government has resulted in a 6.7 per cent real-terms decrease in the Scottish Government's resource budget since 2010-11. However, in the face of such cuts, there has been a real-terms increase in the health resource budget of 3.5 per cent over the same period, and we have delivered on our manifesto commitment to pass on the Barnett resource consequentials to health in full.

In 2015-16, the health budget will, for the first time, rise to more than £12 billion, and there will be a real-terms increase in the total health budget from 2014-15 to 2015-16. In 2015-16, territorial boards will receive allocation increases of 2.7 per cent. That increase is above forecast inflation, which reflects the importance that we attach to protecting front-line point-of-care services. Boards such as NHS Grampian and NHS Highland that are behind the NHS Scotland resource allocation committee parity level will receive an uplift above the 2.7 per cent average to reflect our plans to move all boards to within 1 per cent of NRAC parity by 2016-17, based on the current NRAC shares.

Furthermore, over and above the full resource consequentials of £202 million that are being passed on to the national health service, £53.5 million has been added to the integration fund and a further £32 million has been added to the previously published capital budget to support the continued investment in NHS Scotland infrastructure. The new south Glasgow hospitals project will open in summer 2015 on time and on budget, while continued focus on the maintenance of NHS Scotland's estate and equipment will be supplemented by the progression of projects such as the Royal hospital for sick children in Edinburgh and the NHS Dumfries and Galloway acute services redevelopment, which are being funded through the non-profit-distributing and hub models.

The Scottish Government remains committed to publicly funded healthcare services, for the people of Scotland, that contribute to growth in the Scottish economy. The contrast between Scotland's approach to the health service based on its founding principles and the competition and privatisation that are being introduced in England is growing ever more pronounced. Our record of achievement is recognised internationally as being innovative and aspirational in both its scope and its potential to improve health and healthcare. For example, Scotland is now regarded as a world leader in patient safety.

However, I recognise that serious challenges lie ahead and that we must ensure that we develop our plans to meet the changing needs of the people of Scotland. That is why, in the new year, we will publish an update to our 2020 vision and why, in 2015-16 and beyond we will, first, increase the role of primary care through a focus on keeping people healthy in the community for as long as possible. Secondly, we will integrate health and social care as part of the Scottish Government's commitment to public service reform. Thirdly, we will further improve the quality of care that we provide through the healthcare quality strategy and fourthly, we will focus on reducing health inequalities—in particular, in the context of benefit cuts that will have the greatest impact on people who are at risk of ill health.

For 2015-16, spending will be prioritised on further improving the quality of care that we

provide, improving the health of the population and securing the value and financial sustainability of the health and care services that we provide. That is the approach that we have taken in the health and wellbeing portfolio as detailed in the 2015-16 draft budget, which I commend to the committee.

I am happy to answer any questions that the committee might have, convener.

The Convener: Thank you, cabinet secretary. Aileen McLeod will ask the first question.

Aileen McLeod (South Scotland) (SNP): I welcome the overall increase of £256 million in health resource spending, which will, as you said, see health spending rise above £12 billion for the first time, which underlines the Government's commitment to protecting the NHS resource budget in real terms. The overall fiscal budget has been reduced by 10 per cent since 2010-11 by the Westminster Government, which has included big cuts to capital spending. What is the total health investment in 2014-15 through resource, capital and the equivalent capital value of the NPD model and the hub programme, and what is planned for 2015-16? Will there be an increase in the overall health investment as well as an increase in real terms in resource and capital spending combined?

Alex Neil: I am happy to provide the committee with a detailed analysis of that, as there has been some debate about the comparative figures. There are the figures for cash and real increases, for the difference between the resource budget and the capital budget, and for the value of the NPD and hub capital investment programme, which is sometimes ignored by external analysts. We reckon that had it been straightforward capital investment funded in the normal way, the NPD and hub programme would have been equivalent to about £380 million of capital expenditure on top of our normal capital budget next year.

Let us look at the percentage increases in terms of the cash and real increases. If we include the NPD and hub programme, the overall health budget next year will increase in cash terms by 3.8 per cent and in real terms by 2.2 per cent. If we exclude the NPD and hub programme, there will still be a cash increase of 1.7 per cent and a real increase of 0.1 per cent. Whichever way we cut it—capital or revenue—there will be a real increase as well as a cash increase next year.

Aileen McLeod: Thank you. That helps to clarify the matter.

In your opening remarks, you talked about refreshing the 2020 vision. A core part of the budget this year has been the integration fund. How do you plan to refresh the 2020 vision, which is central to ensuring that our elderly and vulnerable citizens can live at home or in a homely setting for as long as possible? That is central to our aims in the Public Bodies (Joint Working) (Scotland) Act 2014.

Alex Neil: I want to refresh and develop the 2020 vision. First, let me give you an example of where it needs to be refreshed. It is becoming clear, in both primary and acute care, that the particular challenges and complexity of the care that is needed by the very elderly population mean that it requires some additional resource and strategy. That is not going to be a one-off. The percentage of the population who are going to be over 65, over 75 or over 85 will rise significantly. The Registrar General estimates that there will be an 82 per cent increase in the number of over-75-year-olds in the next 25 to 30 years, and I read the other day that the first person in the UK to live to 150 has already been born—you never know, it could be a member of the committee or even someone who is sitting at this side of the room. Two years have passed since the original 2020 vision was developed, so we want to refresh it to take account of emerging developments that were not clear two or three years ago. The complexity of care that the very elderly require is a good example of such a development.

I also want to develop the 2020 vision. In particular, it is important that we consider the capacity that is required to deliver what we are trying to deliver by 2020. As members know, we have substantially increased the staff in the national health service over the past seven years, and nurse numbers have risen significantly over the past year or two.

However, we still have significant skills shortages in key areas. For example, in remote, rural and island communities, we have major challenges in respect of all kinds of health staff. We have particular challenges in specialties including paediatrics and some sub-specialties within cancer. We have to have a positive plan in place to identify how many people we need.

10:00

I also believe—I have made this clear to the British Medical Association and to the Academy of Medical Royal Colleges and Faculties in Scotland, and the view is shared by my colleague Michael Russell, the Cabinet Secretary for Education and Lifelong Learning—that we need in the longer term to increase significantly the number of people who go into medical school. Because so many people are going part time, because of the feminisation of the workforce and because of all the other trends, we will have to increase significantly the number of people who are admitted to medical school to meet future manpower and womanpower needs in the national health service in 10, 15 or 20 years.

I am keen that we look at the forecast level and make-up of demand as much as we can, and that we include in the 2020 plan that we are going to publish an overall strategic approach to capacity. I have already introduced quite a number of new tools, including the workforce tool for planning workforce requirements and the bed planning tool, but I want to look at the overall picture nationally to see what the staffing requirement is to deliver.

The other big challenge in all this is the transition from where we are today to where we need to be. As a society, we have already done that with mental health; we have de-institutionalised a large chunk of mental health services over the past 15 or 20 years. We now need to do something similar with the rest of health provision. We are always going to need hospitals. I am sure that people will always require specialist acute care, but we know that there are in hospital an awful lot of people who, had we the facilities in the community, would not need to be there.

We need that transition to get the facilities into the community and into primary care—social care has a big role to play in this—so that we can stop admitting people to hospital unnecessarily and instead treat them in the community.

Aileen McLeod: I take it that, as well as involving politicians with cross-party support and stakeholders, the refresh of the 2020 vision will give the general public an opportunity to be involved in a discussion about future priorities for the NHS.

Alex Neil: I am keen to involve all the stakeholders, and I am also keen to involve all the political parties and the committee. I am looking at how I can do that once we have set out the basics.

We should try to take party politics out of the health sector as much as possible. I know that that is difficult and I am fully aware of the challenges that it presents for everybody, but it will be helpful if we can have a sensible debate about the way forward without trying to score points over each other. We are all guilty of that—even I am guilty of it from time to time. However, there are major challenges facing the national health service, not least because of the on-going financial constraints that face us, and the more we can have a grown-up discussion about that, looking at the challenges and how we are going to meet them, the better.

Aileen McLeod: Thank you.

The Convener: Thank you for that, cabinet secretary. You know that the committee is up for that honest and frank debate. The more we can cut out the politics, the better. Maybe a new regime with less politics would have toned down some of your introductory remarks a wee bit.

Are you describing new evidence about the ageing process? Has new evidence come to light that can be shared with the committee?

Alex Neil: The new element that I am highlighting is the feedback. We have no quantitative information at the moment, but when we talk to, for example, doctors in accident and emergency departments across Scotland, or to GPs, they are beginning to highlight that the very elderly with very complex conditions are emerging as a group. They usually describe them as people over 85 with very complex conditions, and when those people come into A and E, they require a great deal of complex treatment.

The Convener: Like you and others, we have been dealing with the issue for quite some time.

Alex Neil: Absolutely.

The Convener: What I was trying to press you on was whether there was new information. What you are saying has been evident for some considerable time.

Alex Neil: I am making a distinction. There is loads of quantitative evidence on the number of older people and so on, but what I am saying is that the very elderly are emerging as one of the challenges.

The Convener: But there is no new evidence.

Alex Neil: There is no new quantitative evidence, other than in relation to the age group of people being admitted to accident and emergency, for example.

The Convener: We all accept that there is a problem and we are very anxious to get the facts on the table.

I come to the new evidence on staffing issues. We saw the projected staffing levels and the significant increase in allied health professionals, for example, against a drop in the number of nurses. That policy has changed, and we are now recruiting more nurses and, you tell us, more doctors. However, we have heard in evidence people question how we evaluate what we need in the new workforce. Do we need more doctors, more nurses, more allied health professionals, more carers at a local level or more skilled carers? Do we need to upskill carers at a very local level? How do you evaluate that? Who made the decision, based on the evidence, that our priority is to recruit more doctors rather than those in the other groups, or is the priority to recruit doctors as well as people in all those other groups?

Alex Neil: There are two questions in there. First, how do we better forecast the profile of demand for health and social care in Scotland? As part of our 2020 planning process, I have commissioned a specific piece of work on

forecasting—not just on one-off forecasting but on establishing a more methodological approach to on-going forecasting. When I was in the computer industry, we started with forecasting before we did any budgeting. The first thing was to try to get a forecast of the level of demand in the economy for our products, the market share that we would get and all the rest of it. In health and social care, we need to do that more systematically than we have done in the past. That is part of the work that is being done in preparation for the refresh and development of the 2020 vision and plan. We will discuss that with people once we have the results.

The Convener: But this morning you mentioned that you have had discussions with your colleague in education, Mike Russell, and you have announced that we need to have more doctors coming through the system in the longer term.

This is an important question, even though I am asking it myself. We have been criticised for the absence of forecasts in how we plan services and determine what our needs will be. You have announced a long-term recruitment process to achieve a certain number of doctors. Now you tell us that you will have a systematic approach to overall recruitment. Why have you announced a longer-term plan for doctors, outwith the detailed work that needs to take place to visualise the shape, size and skills of the new workforce for people who, in the main, will be dealt with not in hospital but in the community?

Alex Neil: Let me take the example of GPs. We just need to look at the trend there. In terms of the number of GPs per head, we are, by far, top of the table in the UK. In the past seven years, we have had a 5.7 per cent increase in the number of GPs working in the health service in Scotland. The problems relate to the hours that GPs are working and the pattern of work. For example, there are many more female GPs than there used to be. A lady GP in Ayrshire who runs her own practice advertised last year for a full-time GP. She had to employ three people part-time in order to get the equivalent of a full-time GP. The trends are very much there already—the evidence is already there to show that we will need more GPs even just to stand still, because of the change in the percentage of doctors who want to work part time or retire early.

We know that to meet the needs of an ageing population and a growing population—remember that Scotland's population is forecast to grow to just under 6 million over the next 20 to 30 years—we will need more GPs and more doctors overall. The calculation of the exact quantity that we require is clearly part of the research that we are doing on longer-term demand, longer-term models of working and all the rest of it. It is about not only the number of patients but complexity and the mix of doctors. We know, for example, that in percentage terms far fewer doctors are going into general practice or A and E departments than was the case 40 or 50 years ago, because of the work-life balance. There is very clear evidence on all that.

I am saying to you—I saw that Dr Simpson nodded in agreement when I said this earlier—that the evidence points very clearly to the need to increase the number of people going to medical school to fill the pipeline as required. However, the exact number requires a detailed forecasting exercise.

The Convener: The point that I am getting at is that that is just about meeting demand; it is not about planning for the future. It has been evident to the Health and Sport Committee in this session of Parliament and in the previous one that we are recruiting just to stand still. The point is that, given the money that is going into the 2020 vision, the challenge for us—the Government, politicians and certainly the committee, which is very much up for it—is how we visualise a new workforce that is not based on the existing model and just replacing what was there. In the budget process, we are searching for evidence that what we are doing is changing the nature of how health services will be delivered in 2020. That is what we are doing here, cabinet secretary, and that is what we want to be seriously involved in.

Alex Neil: That will be informed by the forecasting exercise that we are engaging in at the moment to model the demand that is forecast for the future. Forecasting is not an exact science, so it is necessary to build in contingencies and caveats, and we have to translate a national figure into funds that are cascaded down to the regional and local levels. Clearly, I think that we have to get better at forecasting the profile of demand—not only the numbers but the pattern of demand from patients in Scotland—so that we can cater for that demand in the future.

Rhoda Grant (Highlands and Islands) (Lab): You told Aileen McLeod that you would provide the committee with further information, figures and the like. Could you include in that information figures that take into account health inflation as well as normal inflation? Could you also draw up for us—taking into account the director of finance's paper—how the new moneys that are coming forward meet the perceived demand on the health service? That would be helpful for us when we scrutinise the budget.

Alex Neil: I am happy to do that. If the clerk gives us a list after the meeting of the additional information that you seek, we will be glad to provide it. That is not a problem.

Rhoda Grant: My question, which leads on quite well from Duncan McNeil's question on the subject, is about the increasing use of private services in the NHS to meet demand. If I may be parochial, that happens in my area, where there is a need for locums and the like when we have difficulty in recruiting to posts. We all know that private services cost an awful lot more than delivery from within the public sector. What are your plans to meet demand? How do you aim to overcome the use of private services in the NHS?

Alex Neil: First, let us get the overall use of private services into perspective. The share of the budget that went to the private sector in Scotland last year was 0.84 per cent, which was exactly the percentage of the budget that it represented in the year that we came in—it is the percentage that we inherited.

As the Auditor General for Scotland pointed out in last week's report from Audit Scotland, over 2013-14 there was a decline in the use of the private sector in the national health service in Scotland. As part of the local delivery planning mechanism, I have again issued directions in the guidance to boards to further reduce the use of the private sector this year.

Where we use the private sector in Scotland, we do not do so to replace existing capacity in the national health service. That is happening south of the border and it is called privatisation or commercialisation. In Scotland, we use the private sector to buy in capacity that we do not have in the health service. That is a big difference: it is not privatising services; it is buying in from elsewhere capacity that we currently do not have. For example, there are some diagnostic tests that are done in the private sector because we do not have the specialism required to do them, and from time to time there is provision for treatment in the private sector because we do not have the capacity to provide it in the national health service. That is very different from privatising national health service facilities, procedures and operations. The trend—

10:15

Rhoda Grant: I am sorry to interrupt you, but are you saying that the use of locums and British Nursing Association staff are not included in figures for private service provision?

Alex Neil: The locum figures will be included as a subdivision of staffing. Let me make a distinction between nursing staff and medics or clinicians. The percentage of the budget that goes to agency nursing is now down to 0.1 per cent of the total staffing cost for nurses, but across Scotland an average of about 5 to 6 per cent of nursing is provided by bank nurses. The vast majority of nurses already work in the national health service. Although I would like to reduce further the use of bank nursing by some boards and to have more permanent staff, an overall level of bank nursing of 5 to 6 per cent is equivalent to the percentage of supply teachers in the education sector, and I think that it is a reasonable figure, given all the demands on the health service.

I am concerned about the increase in the use of locums for GPs and for other doctors' positions in A and E and elsewhere, particularly short-term locums. Long-term locums are okay in terms of patient safety, but a continual churn of short-term locums can raise issues of patient safety as well as questions about the economics of the health service.

A locum doctor typically costs 180 per cent of the costs of an NHS employee or a GP. Usually, 130 per cent of that goes to the doctor, because they get 100 per cent for normal pay plus 30 per cent for moving about, and 50 per cent has traditionally gone to the outside agency that arranges the locum. We are currently engaged in a process of bringing the organisation of locums in house, so that that 50 per cent can be recycled within the national health service without going to outside agents. That is important, and it is part of our overall strategy to reduce the use of locums.

The way to reduce the use of locums is, of course, to recruit permanent doctors and to try to address the issues that are causing us difficulty in attracting people into general practice. The work-life balance is the main reason why recruitment is difficult. In remote rural areas, the reason given is often not to do with the GP but about finding a job for the GP's spouse. As you know, we have advertised in Ardnamurchan for eight GPs and have so far had only one or two applications. The GPs who were there previously often did not stay long because their spouses could not find employment in the area.

It is a complex issue. There is an overall shortage of certain skills and there is a challenge in getting people to go to rural areas and island communities. The feminisation of the workforce has led to more part-time working in many cases, and there is now anecdotal evidence of a general trend towards part-time working, particularly for people in their late 50s and early 60s, leading up to retirement. There is also anecdotal evidence that, because of pension changes and the reduction in the cap, some doctors are reducing their out-of-hours commitment, and that some doctors are retiring earlier than they otherwise would have done. Those are all challenges in recruiting and retaining the people we need.

Rhoda Grant: I am aware of those challenges; indeed, I have asked you about working with other public and private agencies on career

opportunities for the partners of the staff who are required, to ensure that when they relocate they have a job for, say, a year to 18 months until they find something else in the area. The situation might be fine in the central belt, but it is a huge barrier to those moving out of it. If two people have had careers, offering only one of them a job just will not work. I have done some work with Highlands and Islands Enterprise on the matter. Perhaps you will take an interest in it and push things along.

Alex Neil: As you will know, we have funded NHS Highland—on behalf of all rural health boards in Scotland—to the tune of £1.5 million to look at what more we can do to recruit and retain doctors in rural areas.

Rhoda Grant: If I picked you up correctly, you said that locums are accounted for not in the private provision budget but in the staffing budget.

Alex Neil: Do you want to explain that, Christine?

Christine McLaughlin (Scottish Government): That is right. The information on private sector spend relates to the use of services and hospital facilities; it does not include nurse agency and medical agency spend.

Rhoda Grant: Is it possible to get a note of that along with the other information that the cabinet secretary has said he will provide?

Christine McLaughlin: Yes. We can provide you with the costs for this year.

Rhoda Grant: Thank you. That would be very useful.

Alex Neil: We are in the process of bringing locum arrangements in house. The arrangements have always been dealt with by a private agency, but I would rather have the money circulating around the health service instead of circulating around the private sector.

The Convener: But have locums not always been accounted for in that way? There has been no change in accounting procedures, has there?

Alex Neil: There has been no change.

The Convener: That is fine.

Gil Paterson (Clydebank and Milngavie) (SNP): Good morning, cabinet secretary. I listened very carefully to what you said on the radio this morning and, as the convener said, you announced that you would be spending an additional £40 million on general practitioner services. Is that new money? If not, where has it come from?

Alex Neil: Next year, in addition to passing on the Barnett consequentials, we will be increasing the overall health resource budget by an additional £61 million. We have funded that specific initiative by using up money left in the Commonwealth games reserve, which was part of the health portfolio budget; by using the migrant surcharge, which is part of the fall-out from recent Westminster legislation; and by redirecting money from lower-priority areas of spend to what I think is a top priority of increasing investment in primary care.

Overall, I think that the investment is worth while, and it is part of our general strategy to enhance investment in primary care. Other elements of that strategy include an instruction to territorial boards in the guidance to boards as part of the LDP process to increase their provision for primary care both this year and next. As you will know, we have also negotiated a three-year contract with the GP committee of the BMA in Scotland, part of which is about substantially reducing the bureaucracy imposed on GPs by that contract and freeing them up to spend more time with their patients instead of filling in forms for the Scottish Government or anyone else.

The strategy is also about directing funding to our key priorities. For example, we established a £10 million telehealth fund, which was matched with funding from elsewhere, to extend telehealth services eventually to another 300,000 people with complex conditions throughout Scotland. Moreover, our integration fund will help with the transition from where we are to where we need to be to bring together adult health and social care services and treat people at home instead of in hospital. That is all part and parcel of investing heavily in primary care and community facilities as part of the transition from treating so many people in hospital to treating more people at home.

Gil Paterson: You say that there is the prospect of savings because of that. Do you plan to roll out the funding by board, or by how it would impact on individual practices? A substantial part of my constituency is very deprived but another part is quite well-off. The problems in the deprived area can be seen, but in the well-off area there are an enormous number of elderly people—the average age is something like 89—so there is a problem there, too. Will there be a benefit across the board?

Alex Neil: Our provision of the funding was influenced in part by conversations with a doctor from Milngavie, whom you will be familiar with. He made the point that more of his very elderly patients have been hospitalised because, frankly, there are not enough facilities and resources in the primary care sector to prevent that from happening, yet the worst thing that we can do to somebody of that age is hospitalise them unnecessarily.

We have identified three examples of areas where the money will be channelled: practices in which there is an above-average percentage of elderly or very elderly patients will get additional support; rural communities, remote rural communities and island communities will get additional support because of the particular challenges in those areas; and the deep-end practices will also get additional support. We have a total of seven link workers in the deep-end practices in Glasgow, and those link workers are clearly making a material difference in helping the practices with the challenging situations that they face in their areas. The money could help to fund additional link workers in more deep-end practices if that is what is needed. It is geared towards the areas where pressures exist in the primary care sector.

We also want both this fund and other funds to roll out more of the pilot schemes on a permanent basis. For example, we have what is called the St Andrews model, which is akin to the Alaskan nuka model of GP service delivery, which has been highly successful. We could not just lift the model from Alaska and transplant it, but some of its underlying principles are important. We have piloted the nuka model in Scotland, and a new nuka model is being opened by Jason Leitch, the clinical director of our quality unit, in Edinburgh on Friday. I would like to roll it out further, because it is clear that that model of delivering GP services can be very successful in dramatically improving the outcomes that are achieved by patients while simultaneously reducing the pressure on GPs.

I am very keen to look at new ways of working. We have piloted telehealth services run by GPs for older people with complex conditions, and a number of those pilots resulted, during the pilot phase, in a reduction of up to 70 per cent in the hospitalisation of patients. Through the telehealth fund, the integration fund and the primary care fund, we want to roll out as much of that work as we possibly can, as quickly as we can.

Gil Paterson: Thanks. I might come back to that later.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): My general disappointment is that, 15 years on, nine or 10 pages of the 185-page budget document are devoted to health, and we are still grappling for information. Having said that, I welcome the continuation of the consensus that all five parties achieved in June on the principles of the 2020 vision, and I look forward to participating in that.

The distribution of funding to primary care that the cabinet secretary has just talked about is welcome. It is interesting that the distribution will be on the basis of a practice having an elderly or very elderly population, having a remote and rural population or being a deep-end practice. That is about inequalities, and those were the three principles that NRAC used in distributing funding to health boards from 1999 under the Arbuthnott formula. The approach has been around for 18 years, yet we have not achieved a move from health board funding to funding those practices, so I welcome the fact that the centre will now be more directive on that.

10:30

Can the cabinet secretary provide us with a link to the local development plans? I am having great difficulty in accessing them. It would be useful to see the plans for the current year. We were supposed to see primary care highlighted in them but, in the ones that I have been able to obtain, I cannot see that at all, so I would value that link.

My main question relates to improving health and better public health. The health improvement and health inequalities budget is £55.6 million but, in the draft budget last year, the figure was £64.4 million. Even allowing for the transfer of £4.4 million to family nurse partnerships, there has been a cut in the health improvement and health inequalities budget since three years ago.

If we look down the list under improving health, we see that the budget for immunisations is up. I know that we have new rotavirus and shingles vaccination programmes, which are welcome and are good preventive measures. The pandemic flu preparation budget is down, because we are just restocking for that, of course. However, the tobacco and alcohol misuse budgets have not increased for almost four years; indeed, the alcohol misuse budget is going down.

I am grappling with all the positive and nice things that the cabinet secretary has said about shifting to prevention—the Christie agenda and the agenda that the committee has repeatedly talked about over the years—and I am trying to equate that with a budget in which health improvement funding is being cut, tobacco control funding is being cut in real terms—it has flatlined for three or four years—and funding to tackle alcohol misuse is down. How do those things equate?

Alex Neil: As you probably know, we have made substantial progress in recent years on alcohol abuse, for example, although not as much as any one of us would like.

I will make a general point about the budget. I take the point about presentation. We do not recognise some of the figures that the Royal College of General Practitioners has produced over the past couple of days, but we think that we know where it has made a mistake. One mistake that is being made is in taking one line on the

general medical services contract and assuming that that represents the totality of what is going into general practitioners and primary care.

The same point applies to health improvement and prevention activity. There is a danger in assuming that a particular headline budget line is the totality of money; it is not. As Dr Simpson knows, there are many other aspects of the health budget, including those in the territorial boards' budgets, in which work is going on that does not necessarily feed into budget lines, as we do not put things in twice—obviously, we put them in only once. We have to look at the total picture.

If we look at the total picture on alcohol and tobacco, we see that we are following the right strategies. Indeed, from the latest consultation that we have produced, which covers e-cigarettes, I hope that we will get broad consensus on our approach. Most of the measures do not involve any money being spent from the health portfolio. The moneys that would be spent would be enforcement moneys—probably through the justice budget or the environmental health budget in local government.

The important thing is not what is in a particular budget line but whether the overall strategy is working. There are clear signs that our smoking cessation strategy is working in many respects. I think that our approach would work a lot better if we had minimum unit pricing, but we are achieving some success on alcohol. We have a long way to go, but there are clear signs that we are having a degree of success.

We cannot just take a budget line and relate that to the success or failure of the overall strategy, because many other parts of our budget and other people's budgets come into deciding the success or failure of the strategies.

Dr Simpson: I think that I agree with you on alcohol. Since the Licensing (Scotland) Act 2005 was passed—as a minister, I was responsible for initiating stuff on that with the Nicholson committee—alcohol consumption in Scotland has been dropping, although I think that that has flatlined in the past year. The discounting part of the act has caused an increased drop beyond the parallel drop in England.

Tobacco use really worries me, because it has flatlined for the past few years. We have got it down to roughly 23 per cent but, even before plain packaging, Australia was down at 15 per cent. We seem to be stuck.

If we make subdivisions, we see that we have made little progress on the variations between socioeconomic groups. The more deprived communities are still smoking at a rate of about 38 per cent, which is a significant number. The consequences for the health budget are enormous.

I understand the alcohol budget, because you have your alcohol brief interventions and the justice agenda. We can agree that things are happening there, but tobacco control worries me. We are not making progress on that. For instance, the reductions in pregnancy smoking rates are tiny. We are stuck at 18 or 19 per cent, which is significant. There have been pilots in Dundee that paid people to come off tobacco; I know that the pilots were attacked in the *Daily Mail* and other places, but if something works, it works, and if it works, we should support it.

I do not see where we are going with tobacco control and, if I may say so, the budget line reflects a complacency that your strategy does not reflect. As usual, we have a great strategy, but I question the implementation.

Alex Neil: I will give you an example. My view is that we spend a lot on public health. Every board in Scotland has a public health department with a director of public health and substantial resources. Perhaps we are not maximising the impact of our public health resource. I have asked the acting chief medical officer, Aileen Keel, to look at our whole public health resource and see where we can make it much more effective. I do not believe that we are doing as much as we can. One reason for that might be the division into 14 health board areas, although I do not want to prejudice the outcome of Dr Keel's work.

We are not talking just about tobacco and alcohol. Our public health effort and strategy could and should be doing more with exercise and diet. The three biggest killers in Scotland are stroke, heart disease and cancer, and there are many other diseases. If we could get an exercise regime among the population—even a modest amount of walking—and an improvement in people's diet, we would see substantial improvements through time and a reduction in the incidence of cancer, heart attacks and stroke.

We need to look generally at how to make far greater use of our public health resource in the prevention agenda by concentrating on exercise, diet, tobacco and alcohol, and on drug abuse to an extent, although that is a wider issue.

Dr Simpson: I entirely agree with you. Because public health activity is based in the health boards and they are primarily focused on the acute sector, they are missing something. That is not to cast aspersions on the individuals involved, many of whom are excellent, but that is nevertheless a problem.

Public health is probably the only area in which we should look at what is happening in England. The cabinet secretary and I would agree that we

do not want to go near most of what is happening there but, in England, the responsibility for public health has been moved to local authorities and the community planning partnership equivalents—the health and wellbeing boards and so on.

We need to look closely at the possibility of moving public health into the local authority sector, which could affect exactly the things that the cabinet secretary is talking about. Issues such as alcohol licences and so on are all within the local authority's purview and, to be frank, public health input on, for example, the availability of licences is insufficient to allow licensing boards to confront sheriffs and say that they do not want to allow a licence in a certain area. Authorities do not have the necessary backing of the public health argument.

Alex Neil: I absolutely agree that there is a debate to be had about that. Since the second world war, the public health function has been a bit of a yo-yo in terms of where it has sat. It originally sat in local authorities but, under the Heath reforms of the early 1970s, it was transferred to the health sector, where it has remained ever since. However, local authorities clearly have a role to play in it. We are creating 32 integrated partnerships, which could play a much bigger role, because they will bring together the health service's role and the local authorities' role. There is an opportunity for us to do much more on the public health agenda.

The Convener: We could have a session on that on its own.

Bob Doris (Glasgow) (SNP): This is an opportune moment for a quick supplementary on what Dr Simpson said. The Community Empowerment (Scotland) Bill is going through the Parliament. If Harry Burns, the former chief medical officer, was here, he would talk about tackling alienation, isolation and lack of empowerment as a key driver in getting people to make positive lifestyle choices, such as smoking cessation, alcohol reduction, increased exercise and the like.

In the spirit of Dr Simpson's line of questioning, will the cabinet secretary be doing any work in conjunction with Derek Mackay, who is taking forward work on community empowerment, to map out the public health benefits of community empowerment, particularly in the most deprived communities? I think that Dr Simpson was driving at the connectivity between those who are on the ground, at the grass roots, who try sometimes to deliver a public health message by lecturing people about what they are doing wrong rather than building capacity in communities to allow people to make positive lifestyle choices. Is there any connectivity between your department and what Derek Mackay is doing?

Alex Neil: Yes—absolutely. A ministerial group is looking at the future of community planning partnerships and the need to make them much more proactive about achieving greater complementarity and co-ordination between all the public services at local level. The health boards and the integrated boards, as well as the local authorities, have a major role to play in that.

As Richard Simpson rightly said, a public health issue such as alcohol is not just a health service issue but a local authority issue, an education issue and a criminal justice issue—to pick just three Government departments that are involved. Community planning partnerships are the tool to get an agreed strategy locally, with everybody then delivering their respective bits of the strategy in a joined-up and co-ordinated way. That is how we are developing the community planning partnerships for the future, so that they can be much more effective in that regard than they have, to be frank, been in the past.

Bob Doris: I am glad that you mentioned community planning partnerships. I will not go down that tangent, other than to put on the record the point that communities should be involved in community planning; that should not be just about officials telling communities what they need, which is sometimes the structural problem with community planning partnerships. I will just leave that point sitting there, because that problem can be disempowering.

Alex Neil: That is perhaps for another committee.

Bob Doris: I merely leave that point sitting there.

What is part of the committee's budget scrutiny is the budget line for health and social care integration. I listened to your opening remarks, in which you talked about the £100 million that sits in the baseline budget of territorial health boards and the £73.5 million, which is a significant increase on the stand-alone budget line in the overall health budget.

That is a significant increase in expenditure. Are those moneys that were previously considered to be change fund moneys? Does some of the money relate to that funding? There were change fund resources for innovation in health boards, local authorities and the third sector for integration-type work. How should we view the integration budget line and how is it intended to be used?

Alex Neil: I make it absolutely clear that the integration fund is not a successor fund to the change fund. The integration fund is specifically about helping to manage and oil the wheels of the transition from where we are, whereby we do not

treat people enough in the community—we overhospitalise in healthcare in Scotland.

It is estimated that a third of people who are in Scottish hospitals at any one time could be treated—and treated more effectively—in the community if the facilities existed there. The issue is how to get from where we are to where we need to be. The £100 million is part of the jigsaw; it will help with the transition. We can send you the details, but Michael Matheson has been leading on that work to develop it and help with the transition from hospitalisation to much greater home treatment. The £100 million, which is only part of the overall budget, is not specifically taken from anywhere; rather, when we did a review, we identified that that sum should be allocated to that function.

10:45

Bob Doris: The national Government will work with health board and local authority partners to determine the best use of the £73.5 million. However, the £100 million sits in the territorial health boards, and it is for them to work collegiately with local authorities to derive the changes that are needed.

Alex Neil: Yes. We have had heavy stakeholder involvement across the board, including the third sector, on how to make best use of the money to achieve the objective, which is to make the transition to home treatment, as I said. Other initiatives—they might be joint initiatives or initiatives primarily in the health service or the social care sector—are also part and parcel of the overall strategy to make the transition.

The hospital at home programme, which NHS Lanarkshire initiated, is being rolled out in other parts of the health service. That is another part of the transition from treating people in hospital to treating them at home. The integration fund should be seen in that wider context—it is part of the strategic change that we need to make in the next five years.

Bob Doris: I understand that. The £100 million is for locally set priorities—they might be set by the third sector, the health board or the local authority. Given the principles to which you referred, there is much more of a national strategy in how the £73.5 million is directed.

I mentioned the change fund because it was intended to drive local pilots across 32 local authorities. It was okay if those pilots were not successful; indeed, the point of pilots is to see what does and does not fly. Where the pilots were successful, a transition was to be made from the temporary funding to drive innovative change to embedding that change in what territorial health boards and local authorities do as core business, in order to mainstream the funding. I am sure that the committee will be ready soon to do a final review of how successful change funds have been across the country.

To return to the integration funding, I hope to tease out whether we should expect—I hope that the answer will be no—some of the £100 million to be used to continue some of the pilots funded under the change fund. Rather than mainstreaming the pilots into core service provision, integration funds could be a new budget line for pilots to use. I am driving at whether the £100 million is to fund new things rather than to provide services that health boards, local authorities and the voluntary sector collegiately should be doing anyway. I am trying to tease out how the money should be spent.

Alex Neil: It causes difficulty if we pick out individual bits of money and overdescribe them. What is key is to have an overall strategic approach, which involves going from where we are to where we need to be—treating people at home much more than we do today. We need to do a number of things to achieve that. For example, we need to provide hospital at home much more; we need to develop telehealth and telemedicine services along the lines that I have described many times to reduce the level of hospitalisation; and we need to invest in primary care services that are more targeted at the areas that I announced this morning.

The integration fund is part of that jigsaw. The £100 million is very much aimed at treating the next generation of elderly differently when they go through the system and with different service provision from days gone by. That will be delivered at the local level.

The £73.5 million is for national initiatives. The £10 million telehealth money comes out of the £73.5 million, as does the £40 million that I announced this morning. I hope to increase the £73.5 million if I can.

The integration fund is not about funding projects that are leftover from the change fund, if I can put it that way. The idea is that anything that was successful during the change fund period would be mainstreamed.

I will give an example. The change fund provided funding for a project to create what is called a step-up, step-down facility in Midlothian. That is for people who are en route to hospital or, more usually, for people who are being discharged from hospital. As you know, we have a mounting problem with delayed discharges. We had made substantial progress on them, but this year has seen a major increase in the number, particularly in specific local authority areas. One reason for that is that those local authorities say that they do

not always have the places or the funding to hand at the right time to fund people to go into residential care. Another reason might be that the person's house is not ready—with adaptations or whatever—to allow them to be discharged from hospital.

In Midlothian, a step-up, step-down facility has been created so that, if someone is medically ready to be discharged but their house is not ready for them to go back to or the support package is not in place, they can go into a midway situation where they will be properly looked after. Any medical needs that they have that do not require hospitalisation will continue to be met, and they can stay there and be well looked after until the care package is in place or they are physically fit enough to go home.

I want to see at least one step-up, step-down facility in every part of Scotland because, to be frank, it is a fundamental part of the jigsaw if we are to achieve our objectives of getting people out of hospital and not having them stay there for longer than they need to be there. I expect the integration board in Midlothian to continue to fund that facility on a permanent, mainstream basis.

That is a good example of what we expect to happen. When the change fund projects are evaluated, some that have not worked particularly well will probably end, while some might reappear in a modified format. However, the integration fund is not intended to fund the continuation of change fund projects.

Bob Doris: That is helpful. I am sure that local authorities and health boards are listening to those words. We will come back to scrutinise their expenditure in a few months' time, and it is important to have clarity around that.

The other budget line that I want to look at is the mental health improvement and service delivery line. I am picking lines where I can see increases in order to ask what the thinking is behind them. Before this morning's meeting, I looked at what the Scottish Association for Mental Health report "Worried Sick: Experiences of Poverty and Mental Health Across Scotland" says about the pressures that welfare reform has put on some of the most vulnerable people in relation to mental health services. Some 98 per cent of the clients that SAMH surveyed believed that their mental health had deteriorated because of welfare reform and cuts by the UK Government.

This might be a red herring—I have no idea—but that uplift could be a sign of the additional pressures that are building. The Scottish Government says that £82 million a year is being spent to mitigate the impact of welfare reform across Scotland. Does some of that sit within the health budget? I welcome the significant 6.3 per cent uplift in that budget line, but I would like to know the rationale behind how that feeds into it. When I read the SAMH report, I wondered whether there is a connectivity between the decision that the Government made and these kind of factors.

Alex Neil: We recognise that the financial pressures on people, and particularly people on benefits, are undoubtedly leading to additional stress and in some cases to more severe mental health problems. The role of the link worker in deep-end practices includes working with people who suffer problems because of financial pressure. Often, a lot of support mechanisms are available but people do not know about them. The link worker puts people in touch with those services.

However, the vast bulk of the budget line that you mentioned is to respond to the challenge of dementia. Some of it is for parenting of three and four-year-olds as part of our getting it right for every child strategy, but dementia obviously presents a major challenge. Compared with other parts of the UK, we have been very successful in our rate of diagnosis of dementia. It is now 20 per cent higher than anywhere else, mainly because dementia is one of the health checks that people, particularly older people, undergo when they are admitted to hospital. This is all about recognising the additional resource that needs to go into dementia care.

Bob Doris: Thank you very much. That was helpful.

The Convener: In my humble opinion, I think that that exchange highlights and sums up the challenges that we face in our scrutiny. The £100 million that you said was available has not been taken from anywhere, but it must have come from somewhere.

Last week, Professor Bell asked what I thought was a provocative—not, I should say, controversial—question: who makes the decision to invest in mental health instead of childcare? Who is making those evaluations? To come back to my original theme, is it because we are locked into doing what we have to do in the draft budget that we are being prevented from innovating and making the evaluations of where will bring us the best health benefits? Who, for example, made the important decision to increase the mental health line, change the nature of that spend and get the outcomes that we would want in that respect? Was that decision based on basic demand and need, on changing the services or on getting a greater bang for the buck from that £100 million? What drives these decisions in the Government to ensure that we are getting absolute best value and quality outputs in what is a very constrained situation? That theme of who is making these

decisions, their accountability and the transparency of the whole process has come up in all the evidence that we have received. We want to be able to see where we are spending the money, why we are spending it and what the outcomes are that justify the decisions that have been made.

Alex Neil: The mental health line is very much driven by the needs of our dementia strategy, which we have agreed and published and whose implementation we obviously need to fund. I should also point out that, in relation to children, GIRFEC and the childcare and equality strategies feed into all of that.

However, you make a valid point about how we judge where we get best value for money and where we should put resources in future to ensure that we get what George Reid used to call the best bang for the buck. A fair amount of work on this matter is going on throughout the Government, including the health department. I will get Christine McLaughlin to give you some more detail on this, but one of our organisations promoting good practice—the quality, efficiency and support team, or QuEST—is looking at how we better evaluate the likely impact of programmes to help us decide where best to channel our resources.

Work is also going on in other areas. For example, NHS Health Scotland is doing a lot of work on alcohol abuse, and it has been examining the impact of particular policies and spend. Before people decide the right strategy, they look at the impact of what has worked—and, indeed, what has worked elsewhere—in individual areas. For example, we have looked at the impact of the approach to minimum unit pricing that is taken in Canada, and a lot of what is being done in that respect has originated from looking at what works and what has not worked elsewhere.

Indeed, I note that the Japanese dementia strategy is taking into account what we have done on dementia in Scotland. One of the innovative things that we are doing here is to heavily involve people who have dementia in the design and development of the dementia strategy and the way forward, and that has been a huge plus in the quality of a strategy that is now internationally renowned as very good practice.

There is no single influence; there is a range of influences. In an ideal world we would be able to predict what impact would result from spending money in one area or in another, but the goalposts change as circumstances change. However, you are right to say that Governments not only in Scotland but across the developed world need to get better at evaluating the impact of programmes and where they get the best bang for their buck.

11:00

The Convener: I am more interested in the influence on spending as a major focus of Government strategies, targets and objectives and in how the budget either follows or drives that. I do not know whether you have had a briefing on the sessions that we had last week. I can see Christine McLaughlin nodding, so she must have read that evidence. The committee would be interested in understanding better how the decision-making process is influenced. As we heard last week, there is no problem in gathering statistics about any given thing in the health service, but it was generally recognised that there is a plethora of facts and figures that do not inform the decision-making process and which cloud and in some ways obstruct the transparency of the system. If we are going to have an honest debate, we are interested in looking at the factual situation and at the challenges, and in sharing those challenges. Perhaps Christine McLaughlin could comment on that.

Alex Neil: Before I bring in Christine McLaughlin, I would just like to say that, year to year, a fair chunk of the health budget is already spoken for, because we have 24 A and E departments, 38 acute hospitals and a portfolio of community hospitals, mental health hospitals, GP practices and all the rest of it. We tend to look at two things. The first is the additional money that we are getting year to year—and next year we will have £61 million on top of the Barnett consequentials—and where we can most effectively spend that money to achieve the Government's health objectives and fit in with our strategy. The second thing is that, within the funding that is spoken for, it is possible to make changes.

For example, starting initially in Ayrshire and Arran and now being rolled out across the health service in Scotland, orthopaedic provision has been completely redesigned and what is provided now is what is described as an MSK—musculoskeletal—service. As a result of that redesign, the need for operations went down by 25 per cent. That immediately frees up resource in theatres and all over the place that can then be used for other things. When that happens, decisions can be made at board level to use the resources that have been freed up to do something else that is appropriate.

Those are the two broad areas. Where there is new money every year, a conscious decision is made about the best way to spend that money, based on what we are trying to achieve and where we know we can make a good impact. In addition, continual improvement in day-to-day work and the redesign of services can free up resource that the health service can reuse elsewhere. It is like

efficiency savings. Unlike what happens south of the border, the efficiency savings are recycled within each board to improve service provision. That is another example of how we change the use of resource on a regular basis. I will ask Christine McLaughlin to give you some more detail.

The Convener: I hope that we will get a chance to speak about the other pressures on boards and about the political decisions that we are all party to and their impact on budgets.

Christine McLaughlin: The spending review approach looks at budgets over a three-year period. As part of that, everything that ends up in the spending review will have been assessed using a straightforward template that is a bit more detailed than the impact assessment template. We look at everything from legislative requirements and bill development to whether an area is a key priority for the Government, and we look at whether it is right for programmes that are already in place to continue. Assessments are made against such things as support of the quality strategy and the impact on agreed outcomes.

That exercise is carried out for the spending review and it is refreshed each year as we go through the draft budget exercise. Therefore, there is an element of challenge and scrutiny of all the lines in the documentation that the committee has before it today. In addition, an assessment is made of the level of uplift for boards and what they are expected to deliver with that, and there are sessions on things such as the amount of money to go into additional NRAC funding. Each of those decisions is not driven solely by the financial position but involves looking at how we can deliver the Government's priorities within the financial envelope and at the public value that is delivered.

We are looking to strengthen that approach and to undertake a more fundamental priority-based review of the spend in the directorates on the policy areas and what you see here in the level 3 and 4 detail. We will kick that off shortly to look at what is in the 2015-16 budget, but also in preparation for looking at what will be in the 2016-17 budget.

There is a process in place, but we could still do more as regards quantification of outcomes. The quality and efficiency support team is doing work to provide a more consistent way of identifying the outcomes that are delivered by individual projects. A good example of that is the childsmile programme and oral improvements generally—there is good evidence on the outcomes that are delivered. That is the kind of approach that we need to have across more of our programme lines so that we can have an assessment of public value.

The Convener: So the transformational opportunities are limited to new moneys that come into the system rather than the bulk of the finances, which are already spoken for.

Christine McLaughlin: I do not think that that is the case. We are saying that we always need to look at things; there is never an assumption that a spend will continue. We try to identify whether there is a fit with the quality strategy or whether there is a legislative requirement that means that that spend must continue. When we enter the budget process, no assumption is made that any line item will continue. In relation to the large proportion of the budget that goes to board baselines, I think that Mr Neil was referring to the fact that the decision there is mainly about what performance targets we expect from boards with that funding, and what level of our total budget goes on an uplift to those boards.

The Convener: Has the model that you have described for prioritising allocation been consistent over time? From the evidence that we have received, I accept—and I am sure that other members do, too—that we are dealing with a decade-old problem. It is not the responsibility of the current cabinet secretary or whoever happens to be occupying that position next month—

Alex Neil: Do you have news that I do not?

The Convener: Well, the dogs are barking.

We face a decade-old problem. It has been testified that, a decade ago, when there was a lot more money going into the system, it was difficult to spend. Now, according to some of the evidence that we have received, we are in a situation in which every £1 is counted on. How has the model been adjusted over that decade? Has it been adjusted, or has it simply looked to deal with the immediate priorities and demands rather than allocate funding for transformation?

Christine McLaughlin: One of the very noticeable differences in the past few years has been the assumption that the status quo will not just continue and that every line needs to be justified. It is not assumed that individual lines will just flatline or increase. As you will see in the budget, in some lines there is not the evidence to support continued funding, or there is very clear feedback from those who receive the funding that it is not the best use of funds. In those situations, we will look to decrease that funding or to take it away within a year.

The Convener: I am no expert on this—I have no knowledge of it at all—but it does seem pretty parochial. You are looking at a line. How do we use the budget to transform the service that we currently provide? How do we continue to be world class? It is not about looking at it line by line, is it?

Christine McLaughlin: No, absolutely.

Alex Neil: We start with the big picture. We took a couple of decisions early on, when the crash happened, one of which was on pay restraint versus a policy of no compulsory redundancies. That was a strategic decision. Once you have taken such a strategic decision, certain financial consequences follow.

Another strategic decision that we took, in terms of the Scottish consolidated fund, was that we would pass on the Barnett consequentials for health. Obviously, that has a knock-on effect on all the other budgets. By definition, if you are passing on the Barnett consequentials for health, there is not so much of the Barnett consequentials for the other services. You start at that strategic level, but when you get down to board level, each board has to decide what its priorities are.

The Convener: I understand that, but we are grappling with the evidence that we have. I would not disagree with the decision to ring fence, but it meant that there was less money for local government to deliver the transformation and more care in the community. When the decision was made that there would be no compulsory redundancies, that had an impact on patients in the system. Who made those decisions?

Alex Neil: The Cabinet made those decisions.

The Convener: In full knowledge of the impact?

Alex Neil: Absolutely.

Nanette Milne (North East Scotland) (Con): I have a couple of questions. The convener mentioned allied health professionals. As the shape of the health service changes and there is more focus on community delivery of services, the AHPs reckon—I am sure that they are right—that there will be more demand for their services, because every time something changes, it puts demands on them. Their contention is that a lot of the workforce developments elsewhere are funded but, as yet, there is no funding for the increased expectations on AHPs, and they have a significant concern about that. Will you comment on that?

Alex Neil: We are talking to AHPs about that. There is a difference between, say, a workforce development plan for nursing, and a workforce development plan for allied health professionals. Nursing is one profession; the allied health professionals currently include 12 different professions, so there are 12 different challenges. However, we are in active discussions on that because we recognise, first, that the role of allied health professionals will expand and, secondly, that we need workforce development plans for every one of those professions.

Nanette Milne: I think your comment was that the more health visitors we have, the more people will be referred to AHPs.

Alex Neil: Absolutely. Also, I referred to how we will need to deliver GP and primary care services in the future. That is another example of the greater role for allied health professionals. For example, when Alaska redesigned primary care and GP services, the biggest expansion was in the use of clinical psychologists. I absolutely accept your point, Nanette.

Nanette Milne: I look forward to developments on that, because it was a significant concern that was raised.

A separate issue is the new medicines fund. Clearly, the £40 million for that this year is very welcome. Is that a one-off? If not, how do you plan to manage demand for it in future years? As more new medicines come on stream, what rates of growth would you consider acceptable?

Alex Neil: We have announced that amount for the period up to 2016. The reason for that is twofold. First, it is based on our best estimate of pharmaceutical price regulation scheme revenue which—as you know—is what funds it. That is a completely new source of revenue, and we still have our thumb in the air in terms of what it will be in three, four or five years. I did not think that it was wise to announce anything because I am not sure how much funding there will be beyond the next two years.

The second reason is, of course, that we do not know what our overall budget will be beyond 2016-17. Obviously, a new Westminster Government will be elected next year. I presume that it will undertake a new three-year spending review, so it will probably be at least this time next year before we know what funding is available to us beyond 2016-17. I therefore thought it prudent to set aside money for the new medicines fund, using the PPRS revenue. However, although I have announced the actual sum for a two-year period, I see the need for a new medicines fund in principle as a more permanent feature of what we need to provide.

11:15

Nanette Milne: That is helpful, as it sets the fund in context. I was really not sure where it was going. Obviously, you are not either.

Alex Neil: Money-wise, I am not sure, but we will continue to need the fund.

Nanette Milne: Thanks for that.

Richard Lyle (Central Scotland) (SNP): Good morning, cabinet secretary. A subject that you have not been asked about but which was touched

on earlier by Christine McLaughlin is targets, although you said that you are looking for party consensus on targets. Often, a Government will set a target and the Opposition will attack the Government because it either does not meet the target or fails to raise it. To my mind, health boards' spending in the health service can also be target driven. If a health board does not meet its target on a particular issue, it will reallocate money in order to meet the target. Can you tell me how many targets we currently have in place? Do you think that we have too many targets or that we should have more? Should the consensus between political parties that you are looking for be about discussing what targets should be in place?

Alex Neil: There are 12 health improvement, efficiency, access and treatment—HEAT—targets at the moment. They are not the only targets, but they are the main targets by which we measure the health service. Most of those are to be achieved by March 2015—that is, at the end of the current financial year—which is why we need to look at where we go from there in terms of targets.

Some targets have driven real improvements in the health service in recent years. For example, the treatment time guarantee has driven down waiting lists from six months, nine months or sometimes a year a decade ago, to 12 weeks for most procedures now. Okay—two boards are not there yet, but they are heading in that direction.

Similarly, on the turnaround time of four hours in accident and emergency, every clinician I speak to says "Do not change that target", because it is driven by clinical need and is a very good indication for them not just of performance but of the standard of care that is being provided.

However, I think that there is room for a debate on some of the other targets and how we measure success in the national health service. On my earlier comment on depoliticising the debate, we have a major challenge at the moment with delayed discharges because local authorities, rightly or wrongly, are finding it difficult to provide social care assessments or to place people timeously. That has become a real problem particularly over the past six months or so, and it has a knock-on impact on our ability to meet the A and E target because the beds that need to be freed up to accommodate people who are coming out of A and E are filled with people who are medically fit to be discharged, but are not being discharged because the local authority is unable to do the social care assessment or to find them a residential place.

We must take a whole-system approach. There is no doubt at all that patient flow is absolutely key to the whole thing. An example of the importance of patient flow is the fact that if 10 per cent or less of the total number of patients to be discharged each day are being discharged by lunch time, the chances are that it will be difficult to accommodate the patients who are coming from A and E. However, there is a real difference if that figure is 40 per cent instead of 10 per cent. I was in Crosshouse hospital last week, which has got the figure up to 40 per cent for most of its wards, including orthopaedics. The hospital has seen a fantastic difference in the flow of patients from A and E into the wards. The reason why such a small percentage of patients are discharged before lunch time is nothing to do with their medical condition; it is to do with the timing of consultants' rounds, the availability of pharmacy, the availability of transport home for the patient and so on. It is about co-ordination and management, rather than medicine.

There is huge room for us to make advances in those areas. In part, that is driven by the A and E target. Every clinician I have spoken to has told me not to abandon the four-hour target for A and E turnaround, because it is driving clinical excellence as well as performance. However, as I said, in relation to some targets, including the ones that have to be met by the end of next March, we have to decide whether to keep them going, redefine them or abandon them, and whether the ones that have been achieved should officially become standards rather than targets.

There is a debate to be had about that and I am happy to have an open discussion about how we measure success in the national health and social care system. We also have to take account of the nine strategic outcomes that the integrated boards have to achieve that have been agreed. Clearly, that needs to be reconciled with, and complementary to, any targets that we set in the future.

There are many events that demand that we look at targets. My personal view is that we should keep the key targets on cancer waiting times, TTG and A and E, for example, because they are good measures of the quality, and not of just the quantity, of provision.

Richard Lyle: I welcome most of the comments that you have made this morning and all the points that you have made. Yesterday, I was in Wishaw hospital to visit a friend of the family who is elderly and has gone back into hospital for a second time because of her condition, but she is waiting to get out again. I welcome the comments that you made about people possibly coming out of hospital and going into a care situation before they go home.

I know that you have tried to be innovative in the things that you have done in the couple of years in which you have been cabinet secretary. However, the one touchy subject that people raise is that of how much public-private partnership and private

finance initiative contracts are costing. I know that you have answered many questions in the chamber on the issue. Is there any way out of the situation? Is there any new information about how to recoup the cost or reduce the cost? That could free up millions of pounds.

Alex Neil: We have a team working in the Scottish Futures Trust on aspects of PFI contracts, because I was not satisfied that the individual boards were always monitoring the contracts, which are hefty documents. We want to get as much value for money as possible, but we cannot renege on the contracts or buy them out—I wish that we could, but that would cost a huge amount of money. However, we have already realised some savings. One of the early projects was Forth Valley hospital, from which we have realised a saving of about £6 million over a period of two or three years.

I believe that there is more to be done. For example, recently the cleaning standards at the Hairmyres hospital were found to be unacceptably low. I do not expect the health board simply to renew the contract at Hairmyres without giving the PFI contractor an extremely hard time. I believe that the contractor brought people up from Coventry to clean the hospital. I find some of the behaviour of the PFI contractor at Hairmyres to be totally unacceptable—I am sure that everyone at this table agrees—and I expect NHS Lanarkshire to hold it to account.

Richard Lyle: I was anticipating that Christine McLaughlin was going to say something.

Christine McLaughlin: I want to give you the actual figures in answer to your question. The total spend on PFI and PPP contracts in this current year—2014-15—is £229 million. In the short time that the specialist team that the cabinet secretary has just discussed has been up and running, it has identified savings that would equate to £26 million over the life of the projects that they are looking at. We should start to see some significant savings, given that those projects run for long periods.

Alex Neil: If you look at the details, you will see that the problem is disproportionate for some health boards. For example, because Wishaw and Hairmyres hospitals, which are both in Lanarkshire, are the subject of PFI contracts, NHS Lanarkshire's payments are of the order of £50 million. In fact, Lanarkshire alone accounts for about 25 per cent of the PFI payments that are made every year by the national health service in Scotland. NHS Lothian also pays a disproportionately high share on PFI payments, mainly because of the Royal infirmary of Edinburgh, and the same is true of Forth Valley. On the other hand, a number of health boards have relatively few PFI contracts, but the boards that have such contracts face an additional financial burden in what are very difficult circumstances.

Richard Lyle: You have just made the point that I was about to make, cabinet secretary. As Lanarkshire mainly comes within the Central Scotland region that I represent, I know that PFI payments comprise a high proportion of what NHS Lanarkshire is having to pay out. Hairmyres and Wishaw are exceptional hospitals that have exceptional staff, but their cost to people in Lanarkshire is quite high. As a result, I welcome the savings that you have identified under PPP. These contracts are, as Christine McLaughlin pointed out, costing £229 million per year, but they still have years to run. You have said that the cost of buying out the contracts would be tremendous, but is there no way of convincing the people involved otherwise?

Alex Neil: The issue is not just about getting to the end of the contract. What has been signed for for the end of the contract could also be problematic—to say the least—and we also need to look at a contract's legacy.

Quite frankly, I would never have signed the contracts in a month of Sundays. They are poor contracts—the original Hairmyres contract, in particular, was a disgrace—but we have been landed with them and we have to deal with the consequences of that.

That said, I am not just lying down and saying, "Just keep writing the cheques." We have a dedicated team who, as Christine McLaughlin has said, have already identified significant savings over the lifetime of the projects. They have just started their work, so I am expecting more savings to be made on these PFI contracts. I also expect health boards to take a much more robust approach to monitoring contracts and, when things go wrong, to ensure that the contractors are appropriately and robustly dealt with.

Richard Lyle: Thank you.

Dr Simpson: I have to say that it is really difficult to get a grip on this PFI thing. For a start, because of commercial sensitivity, one never sees the actual contracts.

First, we had PFI, then we had PPP, which was a bit better, and finally we have NPD, which is claimed to be a better form of the original PFI. All of them cover, to a greater or lesser extent, maintenance contracts, cleaning contracts and other things. The maintenance side is important, because it is not included in standard public sector contracts and, according to Audit Scotland, the maintenance backlog has slipped. There are real problems in that respect; for example, the high-risk maintenance backlog is running at £96 million, some of which, as we heard the other day, is capital and some of which is revenue.

Even given commercial sensitivity, would it be possible to get independent analysis of capital charges on public sector buildings—which I presume are currently low because of low interest rates, but which were 6 per cent back in 2000—in NPD versus PFI, with all the different bits spelled out? Otherwise, we will have no understanding of the matter. Our capital budget has been severely cut; indeed, it has suffered most, and public sector capital funding is really very tight in this budget.

11:30

Alex Neil: Because of the nature of the contracts, a direct comparison might not be great, but we will certainly look at that and see what we can furnish you with.

Christine McLaughlin: We can give you the information that I have in front of me, which is about the unitary charges on all the locations and the length of the contract that is left. However, we cannot give you a like-for-like comparison because the information includes different levels of service, so there is not a straight comparison. The financing around each deal will also be different, but we can give you the broad-brush differences between what we expect on NPD, PFI and PPP, if that would be helpful.

Dr Simpson: I would also like a comparison between the NPD and current public sector charges, which are not in the budget. Are the public sector charges on the Southern general, for example, 6 per cent or 4 per cent? What are they going to be?

Christine McLaughlin: I will give you that information. The Southern general might be a good example and a good way of letting you see the comparison. We could make it a case study and work through it if that would be helpful.

Dr Simpson: That would be helpful. Thank you.

Alex Neil: There is no doubt that, if we are borrowing, the cheapest source of capital funding is the Public Works Loans Board. Obviously we will have access to that in the next couple of years.

Colin Keir (Edinburgh Western) (SNP): My first question has just been answered. I blame Mr Lyle, if I am honest.

I am trying to get an idea of the difficulty with introducing the living wage into the national health service because of its budgetary restraints. How does our situation compare with that of colleagues in England? Who has the living wage and who does not? I am looking for a bit more information about that.

Alex Neil: We pay the living wage to everybody in the national health service in Scotland. I am answering from memory, so we will check the figures and get back to you, but I think that I am right in saying that almost 30 per cent of all our employees are on the living wage in the sense that they are at that end of their wage scale. I also think that I am right in saying that there is not a national policy of paying the living wage in the health service south of the border. We will double-check that and come back to you.

As well as the living wage, the way in which we have applied the pay policy in Scotland has opened up a big difference between our approach and that taken south of the border. For example, last year, the Doctors and Dentists Review Body and the agenda for change pay body recommended a 1 per cent increase. We paid that increase and the UK Government decided not to. We have kept progression payments and the UK Government is abolishing them. The UK Government insisted on a two-year deal but we have, as usual, made it a one-year deal so that it will be reviewed again this year. Of course, we also have a policy of no compulsory redundancies.

Let us look at the pay differential for nurses as an example. This year, the lowest grade nurse in Scotland is about £238 better off than her equivalent south of the border. A higher grade nurse will be almost £1,000 better off than her equivalent south of the border. Because ours is a one-year deal, I am about to give evidence to the pay review body on next year's deal. As I said, south of the border it is a two-year deal, so the gaps are likely to increase next year.

I do not take any pleasure in saying that, because I feel sorry for nurses and others in the health service south of the border, but 1 per cent is not a king's ransom, and I think that we are doing the right thing as part of a pay constraint policy that allows us to keep our policy of no compulsory redundancies during these constrained times. We have got the balance right in difficult circumstances.

The living wage is a key part of that approach. Under the pay policy, this year people who are on £21,000 or less can get an increase of up to £300, whereas people who earn more than that will get an increase of 1 per cent.

The Convener: Can we get a global sum for what that costs the national health service? We heard about the leaked paper. The chief executives of the health boards complain about the approach, well-meaning and agreeable to politicians of all colours though it may be. The pension costs have been listed, but we maybe do not know what the on-going 1 per cent increase or the other measures, such as no compulsory redundancies, will cost.

The cabinet secretary said earlier that when we as politicians make these decisions there is an impact one way or the other on the service and its budget. That is what the poor chief executives have been saying in discussions with the Scottish Government. They also complain about the treatment time guarantees. All of us on the committee are interested in how we move that forward, as Richard Lyle said earlier. We have taken evidence that there is a significant cost. It would be interesting to understand what it costs to get another per cent or half a per cent, because that would provide an important perspective.

Chief executives also worry about other political decisions such as the 24/7 service provision trauma network, which costs a lot of money within tightening budgets, and maintaining hospital beds, nursing and staffing levels, which relates to no compulsory redundancies. It is in that environment that we look at a draft budget that gives boards X amount of money, but in the context of increasing demand from the increasing number of people who are presenting at A and E, the increasing elderly population—the boards are doing a lot just to stand still—and the political demands of Government. If I have a chance before we finish, I will come back to the point about the significant costs of drugs and new treatments, which we focused on previously.

It would be interesting to find out some of the costs associated with those decisions, in the light of the chief executives of health boards complaining about the impact.

Alex Neil: The biggest increases that we will face next year are the changes to the employer contributions to the pension scheme as a result of the reforms being introduced south of the border. We do not have a final figure on the cost of that, but we are talking of the order of £70 million potentially. The national insurance changes will have a significant impact as well. Once we get confirmation of those figures, we will tell you.

Christine McLaughlin: For the pensions impact that kicks in from 2015-16, boards have made a planning assumption of a 2 per cent increase, which is reflected in the chief executives' paper. We are expecting the final revaluation to be completed by the end of November, so there will be certainty then about the cost, but we anticipate it being in that region. The impact from losing the rebate on national insurance, which kicks in from 2016-17, is more of a certain figure of 2 per cent, which is factored into the paper as well. They are two significant additional pressures, which have not been present in previous years for the boards.

The Convener: I am talking about all these things, including the impact of political decisions down south. I think that the chief executives estimate the cost of those decisions as somewhere around £100 million in 2016-17, so there is a difference between £70 million and £100 million in that regard. There are also the national insurance decisions that this Government is making. The reality is that the costs to the health service are about the people who work in the health service.

There are all of those decisions and impacts that the chief executives have identified. Can we have the global figure for the impact of no compulsory redundancies, pensions, the cost floor and the living wage? Where is the mitigation in the draft budget for those items to allow people to deliver and change the service?

Alex Neil: Whenever we have the final figures, particularly on some of that stuff, we will absolutely provide the committee with the detail. As I have said, we can give you some of that at the moment. Some estimates still have to be finalised, but we will provide that information.

I will make a point about the treatment time guarantee. It would be a huge mistake to look at that issue only from a very narrow health provider point of view. If people wait for six or nine months for an operation—as was the case 10 years ago, for example—and are off their work for that time, the impact on the economy, let alone the impact on their family budget, will be substantial. Therefore, we cannot just take a view of the matter through the narrow prism of the health provider; we must look at what is right for the Scottish economy. If people can have their operations within 12 weeks instead of 12 months, that will make a substantial difference to the wellbeing of the overall economy.

I do not think that anyone has done an exercise on that in recent times, but I want to register the thought with the committee. I recognise that if we improve the waiting time—12 weeks is now the treatment time guarantee period—by definition we inevitably have to invest in order to meet that target. However, leaving aside the patients, who are obviously the main beneficiaries, the benefits to the Scottish economy in not losing as much output and in wealth creation, for example, are enormous. We always need to look at the wider picture.

The Convener: Yes, I was trying to get at that. Earlier, we spoke about the targets in general, whether there was clinical demand for them, and the fear that the outcome would be poorer quality. We would all accept what you say, but we know when the waiting time targets fail. We know from Lothian about the political consequences, the costs, the increased use of the private sector, and the money flowing out of the national health service.

I do not know whether there is a figure, but we have come a long way. A decade ago, many of us who are sitting around the table were inundated with cases involving people who could not get an operation. They have disappeared in my case load—touch wood—so there have been tremendous gains.

In accepting that we have come a long way, I—and, I am sure, the other members—would be interested to know how much that approach costs and how much finance and resource are being diverted, considering we could create a space to do something different with that money, whether through transferring it into the community or whatever. I do not know, but surely we should have a better understanding of not simply the costs but the costs as part of the overall picture.

Alex Neil: Absolutely—and where we have that information, we are happy to provide it to the committee.

The Convener: Are there any other questions?

Dr Simpson: I have one or two.

First, cabinet secretary, did you say that the £40 million that you announced this morning is out of the £73.5 million? Did I pick you up correctly? It is not new money.

Alex Neil: Yes. It is part of that.

Dr Simpson: It is within the integrated care fund.

Alex Neil: Yes.

Dr Simpson: I wanted to get that clear and on the record.

Secondly, in the previous budget, there was a specific figure for what you applied to NRAC. I will not ask you for it now, but could you indicate it rather than my having to lodge a question on it?

Alex Neil: It is a lot easier just to send it to you.

Dr Simpson: Yes, I thought that it would be easier to ask you now.

Alex Neil: We can do that

Dr Simpson: Thirdly, bed blocking is clearly a vexed issue. We have come a long way since the 3,000 blocked beds in 2003, when we began to tackle that through the programme, but since 2008, when we reached the original target of zero cases over six weeks, the progress has not really been sustained.

Although bits have improved, I suggest that we should move to a target of occupied bed days rather than weeks. A two-week target is crazy; it is just not possible. What will happen is that many more patients will be transferred into the "complex" status and therefore taken on to code 9. That is not what we want. We do not want gaming to occur in order for the targets to be met—we have been through that once already.

Given the problems that you have outlined, with some people having access to step-up, step-down facilities and others not, and some people having adequate care home provision and some not—for example in Edinburgh, which has real problems with care home provision—the real question is: how do we incentivise? How do we provide not only a carrot but a stick?

11:45

In my area, Clackmannanshire, which is a Scottish National Party-led council, and Stirling, which is a Labour-led council, have almost zero delayed discharges. They have made the four-week target and done phenomenally well. However, the Falkirk end clearly has serious problems, which impacts on my constituents' access to Forth Valley royal hospital in Larbert. How do we get Falkirk sorted without saying, "That's because you've failed to spend money on this"? If we give money to the people who have not performed, we are rewarding bad behaviour. I am not saying that Falkirk's behaviour is bad, because I do not know what its problem is, but it has a problem. How do we deal with that?

Alex Neil: We could probably put the challenges and the areas where there are challenges into two broad categories. You have areas such as Edinburgh and Aberdeen where the situation is a function of the local economy. That presents itself in a number of ways. In Edinburgh, for example, 25 per cent of people in residential care are self-funders; therefore, the attractiveness of local authority placements, which are about half the going rate for self-funders, is a factor that is limiting the number of places available for local authorities to place people. We need a strategic solution to that. That is one of the reasons why NHS Lothian is struggling to meet its A and E turnaround target.

According to the College of Emergency Medicine, if we take out the period after patients have been treated in A and E departments, when they are waiting for a bed, they are turned around very quickly, relatively speaking, within A and E. The bit that is causing boards not to hit the target is often the time that patients are waiting to be placed in a bed in a ward. That is often because the beds are not there because of delayed discharges or because the daily discharge profile is not good enough. Those are the two main contributing factors.

In Edinburgh and Aberdeen in particular, there are strategic issues. The care sector is finding it very difficult to get workers because the wages are

low. In Aberdeen, quite frankly, someone would get more money for filling shelves in a supermarket than for working in a care home. We are working with the Convention of Scottish Local Authorities because we recognise in our report—this is public—that we are not paying enough for residential care. We recognise the need for the living wage throughout the social care sector. We are doing a similar exercise on home care because many of the issues are the same.

Overall, therefore, the first category would be the likes of Edinburgh and Aberdeen, where we have a strategic problem. We need a strategic solution to that because they are buoyant economies, and the consequences of a buoyant economy is that there are real problems with getting people to deliver either residential care or home care.

In the second category, it is an issue of management of funding, the lack of integration, the lack of a step-up, step-down facility and a range of other things. That category can probably be more easily solved. I will be expecting the strategic plans presented by the integration boards to have very clear plans to deal with the problem. In areas where we have had integration for many years, such as West Lothian, we do not have delayed discharges, because the whole system is joined up. West Lothian has a step-up, step-down facility, which is one of the reasons why it does not have delayed discharges.

I can tell the committee now that the significant increase in delayed discharge in recent months will have a negative impact on A and E turnaround times, not because of poor performance in any departments but because of the knock-on effect on the availability of beds on wards. I will be absolutely up front about that.

The Convener: It is music to the committee's ears to hear about your discussions with COSLA on the living wage for care workers, and indeed on the quality of training. It is great stuff and we look forward to hearing all about it.

Richard Lyle: I have a small supplementary question, cabinet secretary. As you know, I had an extensive number of years as a local authority councillor—I will not bore everybody by mentioning how many years.

Alex Neil: And you were a very good one, if I may say so.

Richard Lyle: Thank you, cabinet secretary. You do a good job, too.

I agree with the point that what happened in many local authorities was that they substantially reduced their number of care homes. In the Motherwell district of my authority of North Lanarkshire, in my ward, numerous years ago the council closed a care home with 20 or 30 people. The point that I am trying to make is that I totally agree with you, cabinet secretary, that we need to be able to get people who want to get out of hospital once they are well into a halfway house or step-up, step-down facility. Are you and Derek Mackay, along with other cabinet secretaries and ministers, taking steps to look at how we can help councils to get to that situation, using what has been brought in by new legislation?

Alex Neil: I have two things to say. First, I made an additional £10 million available in two tranches of £5 million to help with the immediate issue. I will not make that available every year, because it is to deal with the immediate situation and to help councils over what they perceive to be a particularly difficult period.

Secondly, I have a meeting this week with Mr Swinney and Mr Mackay precisely on this point. The social care budget is part of the local government settlement, and as well as the bilateral discussions that we are having with individual councils to try to help them through the challenges that they say they are finding in dealing with this issue, we will talk to Mr Swinney and Mr Mackay about what else we can do as a Government to try to significantly bring under control the delayed discharges issue.

The issue has a substantial knock-on impact, particularly on patients. If someone is medically ready for discharge but their discharge is delayed, for whatever reason, there is clear clinical evidence that within a 72-hour period their condition starts to reverse and to deteriorate. Clearly, that is the last thing that we want to happen. So, I regard one of my top, immediate priorities as being to work with local authorities to resolve the delayed discharge issue.

Richard Lyle: I welcome that statement and I am sure that many local authorities will also welcome it. Thank you.

Alex Neil: Thank you very much indeed.

The Convener: A mutual appreciation society.

Alex Neil: As long as the councils know that I have got nae mair money.

The Convener: We wish you well anyway in getting money out of Mr Mackay and Mr Swinney, because it is much needed in our communities.

Aileen McLeod: This is the final question, cabinet secretary. The NHS boards survey conducted by the committee found a range of examples of how NHS Scotland's sustainable development strategy had influenced budget decisions. Do NHS boards need to do anything further to achieve the climate change targets? Does the Government need to take any co-

ordinated action on the health budget to achieve the climate change targets?

Alex Neil: There is such action. Mike Baxter, Christine McLaughlin's colleague in the finance department, is leading on it for the Scottish Government and is working with all the health boards, particularly on the energy front. The total energy bill for the national health service is in the order of £70 million a year. We would like to be able to reduce that, not just because of the cost savings but because we want more efficient use of energy throughout our estate.

In the estate strategy that was published last year—I think that the update is due before Christmas—one of the key sections is about the initiatives that we are taking to improve our use of energy and to extend the use of renewable energy resources within the national health service. There are quite a number of examples of where we are doing that. Indeed, where we can, we are keen to be part of district heating systems and the like. So, we are doing that work not in isolation but as part and parcel of the wider Scottish Government effort to improve energy efficiency and to extend the use of renewable energy to replace fossil fuel energy.

Aileen McLeod: Okay. That is great. Thank you very much, cabinet secretary.

The Convener: That was a very good answer to a very good question.

I have one final question—

Alex Neil: This is about the third final question.

The Convener: You thought that you were getting to go.

We spent a lot of time discussing with you the funding of new medicines for end of life and rare diseases. In 2013, you announced £20 million for that, and you have announced £40 million for 2015-16. We know that one of the risk factors that was identified in previous evidence is the increasing drugs bill—we played a part in that by creating a pressure on the health service. We know that the hospital pharmacy bill is increasing by around £10 million per year. The £40 million that you have announced will be on top of that. How did you arrive at the £40 million figure? Do you see it as a one-off, or do you see such expenditure accumulating over the next few years? It has been suggested that it could end up being between £60 million and £80 million, because the £40 million will provide new medicines for X number of patients, but other new medicines will arrive. How do you see that developing?

Alex Neil: As I said to Nanette Milne when she asked me more or less the same question, the £40 million was our estimate of what would be required to fill the gap that the new medicines fund is designed to fill. I know that the committee received an estimate of £70 million from the Scottish Medicines Consortium some time ago; as it turned out, our estimate is much nearer £40 million than £70 million. It so happens that we estimate that in the order of £40 million of the PPRS money, which is new money, is coming to the Scottish Government. We will use that money to fund the new medicines fund.

I think that the new medicines fund will be a permanent feature of the NHS in Scotland, but I have announced the funding only up until 2016 because we do not yet know what funding we will be able to receive from the PPRS beyond 2016, nor do we know what the overall Scottish Government budget will be beyond 2016-17. Although I think that the new medicines fund will be a permanent feature, I cannot realistically set aside money for it until I get the information on how much money will be available beyond 2016.

The Convener: But when prescribing was identified as a risk factor, it was explained to us by the Government and others that the PPRS, which involves medicines coming off licence and so on, would reduce the prescribing demand on the health boards.

Alex Neil: You are referring to generic medicines.

The Convener: It is clear that that will not happen, because that money is not going to the health boards. The saving from the reductions in what we pay for prescribed medicines is not going to the boards. Their hospital pharmacy bills are going up by £10 million a year, on average. Those increasing bills are still a risk for the health boards.

Alex Neil: I have two things to say in response to that. The first is that, before we set up the new medicines fund, which was initially a £20 million fund, the bill for some of the medicines that were made available as a result of the individual patient treatment request process was picked up by the boards. Therefore, some of what was picked up by the boards a few years ago will now be picked up by the new medicines fund, although it is difficult at the moment to be precise about exactly how much of the £40 million will fall into that category.

Secondly, we are looking at ways of having even greater control over the prescriptions budget overall. The prescriptions bill for the NHS in Scotland is running at roughly £1.3 billion a year. As you know, the Auditor General produced a report a few months ago in which she suggested a number of changes that would enable us to save £26 million a year—from memory, I think that that was her suggested figure—and we are working through the recommendations in that report. We also have some ideas of our own about how to get

to a position in which we have better control over prescribing at every level.

12:00

The Convener: So the boards will benefit from that work.

Alex Neil: Exactly.

The Convener: And they will be able to retain that money.

Alex Neil: Absolutely.

The Convener: Do you see the £40 million in the new medicines fund as money that will not grow but which will, in effect, be capped until 2016?

Alex Neil: At the moment, we think that it will not go above £40 million. Of course, if unmet demand were to emerge, we would have to decide how we would fund it. However, we are fairly comfortable that the £40 million that we are setting aside will be enough to provide for demand.

I should tell the committee about an exercise that NHS Forth Valley carried out last year to improve control of the dispensing of statins; as a result of the new methods that have been introduced, it reckons that it will save £6 million a year on statins alone. I merely pick that as an example, but I think that there are still quite a lot of potential savings to be made on the drugs bill. Indeed, if every health board were as efficient at managing its drugs bill as the best are, we would save tens of millions of pounds on the drugs bill every year. That is the position that we are trying to get to.

Christine McLaughlin: We have done quite a lot of work on trying to understand the scenarios around the costs of the new SMC process. I should say that what we are talking about is not an absolute figure; it all depends on the assumptions, which is why our figure differs from the original estimates that you received. However, the £40 million makes sense to us, because that is what we are expecting in terms of receipts, and we also believe it to be a realistic estimate of this year's costs. Nevertheless, the figure might be higher or lower, and now that we have a new process, particularly for resubmissions, we will look at it again. We have put in place quite a detailed process to identify the impact on costs, and we are geared up to get regular information from the boards to allow us to report quarterly on the actual costs in the new process.

The Convener: And you can provide the committee with similar workings for the £40 million.

Christine McLaughlin: We will be able to collate that information on a quarterly basis and see the actual spend, which will allow us to look into 2015-16 and see how realistic our estimates are against the £40 million. However, all of that money will go to the boards based on spend.

The Convener: Thank you very much for that. As members have no more questions, I thank the cabinet secretary and Ms McLaughlin for their time and for attending the meeting.

Alex Neil: It was a pleasure, convener.

The Convener: As agreed, we will now move into private session.

12:02

Meeting continued in private until 13:02.

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